Applied Behavior Analysis Services Workshop

Mo Division of Developmental Disabilities October 31, 2016

Objectives for behavioral service providers

- Familiarize you with the regulation under which behavioral services are governed for Mo DDD
  - Definition of ABA services and requirements as established in new directive and draft rule, and other statutes and rules
  - Requirements for services and documentation, treatment plans, etc.
- Review the Standards of practice for behavior analysts from
  - Licensure regulations
  - BACB practice standards and ethical compliance codes
  - Autism Treatment guidelines
  - Other best practice guidelines
- Review and discuss the CPT
  - History and purpose
  - Definitions of ABA services for Mo DDD
  - Discuss behavioral interventions/practices and which code is appropriate
- Review the preauthorization process and provide suggestions for making this smoother

Objectives for DD provider relations staff, support coordinators and private TCM staff

- Overview level understanding of behavioral services and what to expect for quality services
- Able to interpret and support behavioral provider assessment and intervention plan UR requests
- Aware of new directives for behavioral services and restrictive supports
- Aware of and understand need for and use of Safety Crisis Plans

From Directive on Behavioral Service Requirements and Restrictive Interventions

Division Directive 4.030

Some Important Definitions

- Behavior Support Plan – A part of the Individual Support Plan that is comprised of behavior analytic procedures developed to systematically address behaviors to be reduced or eliminated and behaviors and skills to be learned.
- Individual Support Plan (ISP)— A document resulting from a person-centered process directed by the individual served, with assistance as needed by a representative, in collaboration with an interdisciplinary team. It is intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the person served. The process may include other people freely chosen by the individual who are able to contribute to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes and the training, supports, therapies, treatments, and/or other services that become part of the individual support plan.
- Least Restrictive Procedure – A procedure that maximizes an individual's freedom of movement, access to personal property, and/or ability to refuse while maintaining safety. The degree of restrictiveness is based on a comparison of the various possible procedures that would maintain safety for the individual in a given situation.

Definitions continued

- Reactive Strategies- The use of immediate and short term procedures that are necessary to address dangerous situations related to behaviors that place the person or others at risk. Such procedures, if utilized as a first time response to an emergency situation.. Procedures include blocking and physical restraints. . This also includes responses that are more delayed such as restricting access to the community or increased levels of supervision. These are procedures used in direct reaction to the undesirable behavior as opposed to proactive and preventative strategies designed to address the undesirable behaviors in a positive fashion.
- Reactive Strategy Threshold -. The use of three or more reactive strategies within a six month period, or two or more reactive strategies in a two month period.
- Regional Behavior Support Review Committee- A peer review committee chaired by a Division, appointed Licensed Behavior Analyst and functions to provide technical assistance to individuals and their support teams and to contribute to the likelihood that Medicaid waiver assurances are kept best practice of behavioral services are sustained.
- Restrictive Interventions –The use of interventions that restrict movement, access to other individuals, locations or activities, restrict rights or employ aversive methods to modify behavior. These may also be called restrictive supports, procedures or strategies.
- Safety Assessment (Attachment A) –assessment by the planning team and physician of an individual's physical, and/or emotional status. This includes history and current conditions that might affect safe usage of any reactive strategies, and identifies those reactive strategies which should not be used with the individual due to medical or psychological issues of safety. The safety assessment should be completed annually or on the occasion of any significant change.
- Safety Crisis Plan (Attachment B) –An individualized plan outlining the reactive strategies designed to most safely address dangerous behaviors at the time of their occurrence or to prevent their imminent occurrence

Definitions continued

- Time-Out –
- 1.**Exclusion time-out** is the temporary exclusion of an individual from access to reinforcement in which, contingent upon the individual's undesirable behavior(s), the individual is excluded from the potentially reinforcing situation but remains in the same area with others present.
- 2.**Seclusion time-out** is the temporary and time-limited removal of an individual to an area or room in which there is limited access to reinforcement and the individual is not allowed to leave the area or room through the use of verbal directions, blocking attempts of the individual to leave, or physical barriers such as doors. or until specified behaviors are performed by the individual. Locked rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited. This is sometimes referred to as a safe room or calm room.

From Directive on Behavioral Services and Restrictive Interventions

Contracted providers shall monitor and implement positive proactive strategies to reduce the likelihood that an individual will require reactive strategies or restrictive interventions. Providers will develop processes to review usage as the threshold criteria for reactive strategy is reached.

- When individuals reach the reactive strategy threshold shall trigger the planning team's extensive review and analysis of the problem situations. The planning team should:
  - Convene within 5 business days to complete the review and any modifications.
  - Identify triggers, preventative strategies and barriers to using the least restrictive strategies;
- Consider the need for a functional behavior assessment, and development of a formal behavior support plan or revision of an existing behavior support plan ;
- Develop new or revised proactive strategies and strategies to prevent situations that are likely to result in use of reactive strategies.
- Any individual meeting the reactive strategy threshold for two consecutive quarters shall be referred to the Regional Behavior Support Review Committee for consultation. If an individual meets the reactive strategy threshold for three or more quarters in a two year period, the planning team shall request behavioral services.

Restrictive Interventions

- Interventions other than approved physical crisis management procedures shall not be used as an emergency or crisis intervention.
- Use of restrictive procedures that meet the definition of reportable events per CSR require completion of the event monitoring form as specified.
- Plans using restrictive interventions shall be reviewed by the Due Process Committee and approved by the region's Behavior Support Review Committee.
- Restrictive interventions are utilized only as alternatives to more restrictive placements and only as a means to maintain safety and allow the teaching of alternative skills that the individual can utilize to more successfully live in the community.

Restrictive Interventions continued

- The ISP must include justification for any modification(restrictions). . The following requirements must be documented in the person-centered service plan:

1. Identification of a specific and individualized assessed need;
2. Documentation that the positive interventions and supports used prior to any modifications to the person centered service plan;
3. Documentation that less intrusive interventions were tried but were not successful.
4. Regular collection and review of data to measure the ongoing effectiveness of the intervention;
5. Established time limits for periodic reviews to determine if the intervention is still necessary or can be terminated;
6. Informed consent of the individual;
7. Assurances that interventions and supports will cause no harm to the individual as described in 42 CFR 441.301(c)(2)(xiii).

Behavior Support Plans

- Must only be developed by a licensed behavioral service provider in collaboration with the individual's support system. The techniques included, in the plan, must be based on a functional assessment of the target behaviors. The techniques must meet the requirements for the practice of applied behavior analysis under Section 337.300. to 337.345 RSMo.

- This includes anything that is directly addressing behavior excesses or deficits with other than positive, proactive and teaching based procedures generally used by non-behavior analysts.
- Even if called Positive Behavior Support Plan or any other title

The behavior support plan must include the following information:

- Alternative behaviors for reduction and replacement of target behaviors, defined in observable and measurable terms. They must be specifically related to the individual and relevant environmental variables based on functional behavior assessment (FBA);
- Goals and objectives for acquisition of coping skills appropriate alternative behaviors;
- Interventions aligned with positive functional relationships described in FBA including strategies to address establishing operations, contextual factors, antecedent stimuli, contributing and controlling consequences and physiological and medical variables; Data collected must include antecedents/triggers, description of events, duration, consequence/result, and effects of interventions. If restraints or time-out are used monitoring of health status will be observed and data documented for one (1) hour after the event in 15 minute intervals. Health status data will include monitoring of vital signs including pulse and visual observations of energy/lethargy level, engagement with others or other observed reactions.
- Description of specific data collection methods for target behaviors to assess the effectiveness of the strategies and data collection methods to assess the fidelity of implementation strategies;
- Data displayed in graphic format, with indications for the environmental conditions and changes relevant to target behaviors;
- Proactive strategies to prevent challenging behaviors, improve quality of life, promote desirable behaviors and teach skills, that are specifically described for consistent implementation by family and/or staff;

Behavior support plan requirements continued

- Specific strategies with detailed instructions for reinforcement of desirable target behaviors;
- Specific strategies to generalize and maintain the desired effects of plan, including strategies for fading contrived contingencies to natural contingencies to support system changes and maintain these strategies after BSP is faded;
- A Safety Crisis Plan if it is necessary to have strategies to intervene with at risk behaviors to maintain safety;
- If a plan includes physical restraint or time-out, specific criteria and procedures are identified;
- Target behavior(s) related to the symptoms for which psychotropic medications were prescribed and when they should be administered and the process for communicating data with the prescribing physician;
- Description of less restrictive methods attempted in the past, their effectiveness, and rationale that proposed BSP strategies are the least restrictive and most likely to be effective as demonstrated by research or history of individual;
- The method of performance based training to competency for care givers and staff providing oversight. Data will be reviewed at least monthly by qualified program staff. The qualified behavioral service provider will review data at least monthly

- Description of how plan will be communicated to all supports, and services. including the frequency with which the ISP team will receive updates

Use of Time Out Requirements are many. Why? It is not an easy procedure to use and CMS requires that we have extra precautions.

- Utilization of a seclusion time-out (or safe-room) procedure requires:
- that there be a functional assessment of the target behavior,
- a behavior support plan,
- request to the Chief Behavior Analyst, in writing, specifying the rationale for the use of the procedure,
- and approval of the designated time-out area or room,
- The individual support plan must identify the need for such restrictive procedures and include behavioral services to support the individual to learn alternative behaviors and less restrictive supports.

Use of Time Out requires…

- A specialized crisis procedure can be approved to utilize seclusion time-out as an emergency procedure with the approval of the Chief Behavior Analyst. Policies and procedures for utilization in the specialized program should include all of the requirements for the Behavior Support Plan.
- Behavioral services must remain active during the time period in which the behavior support plan (seclusion time-out intervention) is in place.
- The Behavior Support Plan when it includes a time-out procedure must include all elements identified in (4) as well as the following:
  - Specification that only qualified personnel may use seclusion time-out for an individual under conditions set out in an approved behavior support plan.

Use of Time Out requirements continued

- Time-out areas or rooms shall meet the following safety and comfort requirements:
- Areas and rooms to be utilized for seclusion time-out and the procedures for the use of time-out shall be reviewed and approved by the Chief Behavior Analyst or designee.
- Continuous observation of the individual in the area shall be maintained at all times.
- Adequate lighting and ventilation shall be used at all times.
- The area or room shall be void of objects and fixtures such as light switches, electrical outlets, door handles, wire, glass and any other objects that could pose a potential danger to the individual in time-out.
- If there is a door to the room or area, it will open in the direction of egress such that the individual in the room is not able to bar the door to prevent entry.
- The door shall be void of any locks or latches that could allow the door to be locked without continuous engagement by a staff person.
- The room or area will be **at least** six feet by six feet in size or large enough for any individual, who will utilize the room, to lie on the floor without head or feet hitting walls or door.

Time out procedure requirements continued some more….

- Release from time-out criteria is limited to no more than five minutes of calm behavior.
- Total duration for the seclusion time-out episode shall be no more than one hour except in extraordinary instances (during initial stage of program) that are personally approved at the time of occurrence by the behavior analyst and reviewed within one business day by the region's assigned area behavior analyst.
- Continuous observation of the person in time-out.
- Seclusion time-out will be discontinued if there are any signs of injury or medical emergency and the person will be assessed by appropriate medical personnel.
- The date, time and duration of each time-out intervention shall be documented on a data sheet and on an event management form

If the behavior support plan includes time-out, it shall be reviewed and approved by the following:

Regional Office's Behavioral Support Review Committee;

- Regional Office's Due Process Review Committee;
- The individual or the family, or legal guardian as appropriate;
- The Chief Behavior Analyst or designee shall use the Time-out/Safe Room Request Tool to evaluate that the plan is appropriate (Attachment C).

Safety Crisis Plans

- A safety crisis plan must be developed after the first use of any reactive strategy or when the personal history of the individual indicates there is a likelihood that reactive strategies may be needed in the future, or where the individual's support team plans to use reactive strategies. A template for the safety crisis plan is provided in Appendix A and B.
- If reactive strategies are considered likely and necessary, the team shall be proactive and consider the need for more specialized support strategies in the ISP and services such as Person Centered Strategies Consultant or Behavior Analysis Services (see Medicaid Waiver service definitions).
- Procedures identified must be those identified as least restrictive and within safety parameters of the safety assessment. These will be used as a last resort after implementation of proactive, positive approaches.
- If a safety crisis plan includes physical restraint or time-out, specific criteria and procedures are identified.
- The plan must include the informed consent of the person, their parent or guardian.
- The safety crisis plan will be considered a part of the Individual's Support Plan.
- Safety crisis plans shall be part of any Behavior Support Plans.
- Use of physical restraint and the name of the approved or nationally recognized crisis management program must be included in the individual's Safety Crisis Plan (as required in RSMo 630.175.1).

Regional Behavior Support Review committees

- Each Regional Office shall have a Regional Behavior Support Review Committee (RBSRC).
- The Regional Behavior Support Review Committee will be chaired by a qualified behavior analysis service professional that meets the requirements of the Division Directive for RBSRC.
- This committee shall review the restraints and restrictive interventions used for individuals in the region who are referred to the committee for consultation or who are considered by the region's assigned Area Behavior Analyst to be at risk.
- Members of the committee will be licensed professionals whose scope of practice and training includes specialization in Applied Behavior Analysis.

From Medicaid Waiver Manual

Behavior Analysis Services

- This service is designed to help individuals demonstrating significant deficits (challenges) in the areas of behavior, social, and communication skills acquire functional skills in their homes and communities and/or to prevent hospitalizations or out-of-home placements.
- Behavior Analysis services may be provided to assist a person or persons to learn new behavior directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors.
- Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions.
- Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.

Behavior Analysis Services continued

- An individual's Behavior Analysis Services are based on the Functional Behavioral Assessment (FBA) which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations;
- The plan should describe strategies and procedures to generalize and maintain the effects of the behavior support plan and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan;
- The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session;

Behavior Analysis Services continued

- The service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery;
- Data should be displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph.
- The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior, and strategy changes
- Performance based training for parents, caregivers and significant others in the person's life are also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.

Functional Behavioral Assessment (FBA)

- FBA is a comprehensive and individualized strategy to identify the purpose or function of an individual's behavior, develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions.
- The FBA which identifies functional relationships between behavior and the environment
- including contextual factors, establishing operations, antecedent stimuli, contributing and
- controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations

FBA continued

- The FBA provides information necessary to develop strategies and recommendations to proactively address the challenging behaviors through skill development, prevention of problem situations and contributing reactions and interactions with significant persons in the life of the individual. These recommendations and strategies are more thoroughly delineated in the person's behavior support plan.
- An FBA current within the past two years is necessary for other behavioral services to be used.
- The process of the FBA includes gathering a written and oral history of the individual, including data, interview of significant individuals who have been involved with the person during times of challenging behaviors as well as times when the person does not have challenging behaviors, observation of the person in a variety of situations, data collection and review, and for the most complex behaviors and situations a systematic manipulation of possible controlling and contributing variables.
- This information gathering process should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.

FBA continued

- A FBA must result in a written document that evaluates if behavioral services are necessary or appropriate,
  - explains the probable functions of the behavior with identification of situations that make it worse and/or have kept the behavior happening, [more than just a simple statement like: the behavior is maintained by escape from demands or social attention]
  - what needs to occur to change the behavior, recommendations for likely effective strategies (not specifically described for implementation as in a behavior support plan),
  - and likely duration and intensity of the service.
- There will be situations in which an assessment will be needed to determine if other services or if behavior services might be appropriate.
- Not every instance of assessment will lead to behavioral services. If changes in situations occur, a new assessment might be warranted.

Behavior Analysis Service Documentation

- Behavior Analysis providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP and the individual behavior support plan.
- Progress notes should be reviewed for program fidelity and consistency, note any concerns, document contacts made with Behavior Intervention Specialist, family, caregivers, etc., any actions taken and modifications made to the behavior support plan. Written data shall be submitted to DMH authorizing staff as required. The Functional Behavior Assessment must not be billed until the assessment is complete and the FBA report has been finalized and received by the support team.
- A copy of the written individual behavior support plan, interventions utilized, and progress notes during Behavior Analysis services, together with a written individual plan of care upon exiting intensive therapy will be filed in the individual's chart, located in the Regional Office or with the Targeted Case management entity with whom the individual is enrolled.

BACB ASD Practice Guidelines

Written for healthcare funders and managers including government health programs and employers

Provide clinical guidelines for ABA as a treatment for ASD

BACB ASD Practice Guidelines

Essential Practice Elements of ABA

1. Comprehensive Assessment – specific levels of behavior *at baseline, informs goals*
2. Emphasis on understanding the current and future value of behaviors targeted for treatment
3. Practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related to improved health and levels of independence
4. Collection, quantification and analysis of direct observational data on targets
5. Efforts to design, establish, and manage the social and learning environments to minimize problem behaviors and maximize progress toward all goals

Essential Practice Elements of ABA continued

6. Approach to treatment links the function to the intervention strategies
7. Use of carefully constructed, *individualized* and *detailed* behavior-analytic treatment plan
8. Use of treatment protocols that are implemented repeatedly, frequently and *consistently across environments*
9. Emphasis on ongoing and frequent direct assessment, analysis, and *adjustments to the treatment plan*
10. Direct support and training of family members and other involved professionals
11. Comprehensive infrastructure for supervision

Guidelines for Autism Speaks

Planning and Ongoing Assessment

* A qualified and trained behavior analyst designs and directly oversees the intervention.

* The analyst's development of treatment goals stems from a *detailed assessment* of each learner's skills and preferences and may also include family goals.

* Treatment goals and instruction are developmentally appropriate and target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and academic skills.

* Goals emphasize *skills that will enable learners to become independent* and successful in both the short and long terms.

Other sources describing standards of practice

Guidelines for Autism Speaks continued

* The instruction plan breaks down desired skills into manageable steps to be taught from the simplest (e.g. imitating single sounds) to the more complex (e.g. carrying on a conversation).

* The intervention involves *ongoing objective measurement* of the learner's progress.

* The behavior analyst frequently reviews information on the learner's progress and uses this to adjust procedures and goals as needed.

* The analyst meets regularly with family members and program staff to plan ahead, review progress and make adjustments as needed

Some other guidelines for ABA

- BACB Task List – Fourth Edition
- BACB Professional and Ethical Compliance Code for Behavior Analysts (approved 2014)
- BACB Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2nd edition
- Celiberti, D. (2012). Quality Indicator and Standards Review in Autism Treatment
- Autism for Public School Administrators: What you need to know. http//wwwautismnj.org/Publications.aspx

Standards for documenting work from BACB Ethical and Compliance code (2014)

2.10 – Documenting Professional Work and Research

a. …to facilitate *provision of services later by them or by* other professionals, to ensure accountability, and to meet other requirements of law
b. Maintain documentation *in the kind of detail and quality that would be consistent with best practices* and the law

2.11 Records and Data

a. Create, maintain, disseminate, store, retain, and dispose of records and data in accordance with applicable laws. Regulations and policy
b. Retain records for at least 7 years unless otherwise specified by law

What does this mean?

- Each service, on each date of service, must have adequate documentation to meet these requirements and professional standards
- LBA should be signing off on all documentation with appropriate signature and professional relationship for RBT and LaBA
- Behavior Support Plans should be dated for date developed (and implemented) and the behavior analyst/provider who developed it should be identified

Standards for Assessing Behavior from BACB Ethical code

3.0 Behavior-Analytic Assessment

a. Behavior analysts conduct assessments prior to making recommendations or developing behavior-change programs. The type of assessment is determined by client's needs and consent, environmental parameters, and other contextual variables. When behavior analysts are developing a behavior-reduction program, they must first conduct a functional assessment.
b. Behavior analysts have an obligation to collect and graphically display data, using behavior –analytic conventions, in a manner that allows for decision and recommendations for behavior-change program development.

20 CSR 2063-6 Standards of Practice

- Ethical Rules of Conduct – principles governing the practice of behavior analysis
- Based on the BACB code of ethical conduct and standards for other similar professions in the state of Missouri
- Delineates regulations for competence, reliance on scientific knowledge, maintenance and retention of records, continuity of care, multiple and prohibited relationships, client welfare, interrupting or terminating services, unnecessary services, rights of clients, confidentiality, integrity and representation of title and services, remuneration, and other ethical issues

20 CSR continued

Functional assessment- a variety of systematic information gathering activities regarding factors influencing the occurrence of a behavior (e.g. antecedents, consequences, setting events or motivating operations) including interview, direct observation, and experimental analysis.

Effective treatment- both short and long term benefits to clients and society

In those instances where more than one scientifically supported treatment has been established, additional factors may be considered in selectin interventions, including, efficiency and cost-effectiveness, risks and side effects, client preference and practitioner experience and training

AND NOW the CPT codes

From ABAI Behavior Analysis CPT Code Workshop by Travis Thompson, PhD, LP

- Retrieved from the ABAI website
- CPT code development, Current Procedural Terminology codes developed by the American Medical Association for billing by ALL medical practitioners and health care providers
- Provides a standard method of medical billing, mandated by Congress
- No CPT means a given service is not likely to be available to patients (clients)
- Type I codes are temporary and allow for national data to be collected to be used to determine how widely a code (service) is used and likely reimbursement rates

CPT codes basic information from Thompson

- Not developed by behavior analysts – there was consultation to the committee of physicians
- They cannot specify a specific degree, license or training
- Up to the states to define a Qualified Health Care Professional
- Can not specify a diagnosis for which a procedure is appropriate
- Can not use professional jargon in definition unless it is broadly accepted by the medical community

Applied Behavior Analysis (ABA)	**Code(s)**
Observational Behavioral Follow-Up Assessment	0360T & 0361T
Exposure Behavioral Follow-Up Assessment	0362T & 0363T
Behavior Identification Assessment	0359T
Exposure Adaptive Behavior Treatment with Protocol Modification	0373T & 0374T
Adaptive Behavior Treatment with Protocol Modification	0368T & 0369T
Adaptive Behavior Treatment by Protocol by Technician	0364T & 0365T
Family Behavior Treatment Guidance	0370T
Behavior Treatment Social Skills Group	0372T

Applied Behavior Analysis (ABA) or Behavioral Services

- ABA services are available to participants in the DMH Waivers. There are two* primary types of ABA services:
- "Assessment services" which analyze the situation and lead to recommendations (described in the "Behavior Support Plan") for how to address the issues, and
- "Adaptive Behavior Treatment services" which are made up of several different methods of treatment, most of which *could* be used alone but which, far more frequently, are used in various combinations.

Assessment Services

- *A "descriptive assessment" comprised of at least these two services:*
  - **Behavior Identification Assessment**, (0359T) AND
  - **Observational Follow-up Assessment:** (0360T and 0361T)
- *And possibly this service as well:*
  - **Exposure Follow-up Assessment** (0362T and 0363T)

Adaptive Behavior Treatment continued

- The following could be a stand-alone service if that was the recommendation of the assessment, but likely are used in combination with each other:
  - **Adaptive Behavior Treatment by Protocol Modification** (0368T and 0369T)
  - **Treatment Social Skills Group** (0372T)
  - **Exposure Adaptive Behavior Treatment with Protocol Modification** (0373T and 0374T)

- The services below would not be a stand-alone service, but might be used in conjunction with the services (a) above:
  - **Adaptive Behavior Treatment by Protocol by Technician** (0364T and 0365T)
  - **Family Treatment Guidance** aka "Family Behavior Treatment Guidance" (0370T)

Assessment Services

Behavior Identification Assessment

(0359T)

- Done by QHCP
- Review of Records
- Interview of Significant persons
- To identify target behaviors, situations for observations, past interventions, medical issues related, etc.
- 2 units per year considered untimed

Observational Behavioral Follow-up

(0360/0361T)

- Observation in various settings- with data-interpretation by QHCP
- Done by RBT, LaBA or QHCP
- ABLLS or VBMAPP
- Other skills assessment
- Develop (QHCP) hypotheses of function, SDs and EOs for intervention strategies (QHCP)
- Report of FBA results and initial intervention plan with goals (QHCP)
- 30 minute unit

Exposure Behavioral Follow up Assessment

(0362/0363T) *

- Designed by LBA
- Onsite oversight by LBA trained in functional analysis methodology
- LaBA or RBT can implement
- When other assessment services have not resulted in reasonable hypothesis for designing intervention or for significantly dangerous behaviors without reasonable hypothesis
- 1st unit per date 60 minutes, add'l units per date 30 minutes

Exposure Assessment

A request for an exposure behavioral assessment should include the following:

- Description of the behavior(s) that pose significant risk of harm to the individual or others;

and

- Description of how to expose the individual to social or environment stimuli associated with the dangerous behavior;

and

- Description of how the assessment will be conducted in a setting conducive to the safety of the individual and other individuals who may be present, including but not limited to physician, other qualified health care professional, or technician.

From Thompson

- Adaptive Behavior Codes
  - Comprehensive Early Behavioral Intervention
  - Individualized Interventions for less severe challenging behavior in natural environments that incorporate promoting adaptive skills
- Exposure Codes
  - Clinical functional behavior analysis interventions (Iwata, Wacker) in an isolated setting such as an enclosed protective treatment room within a clinic or hospital
  - Functional Behavioral Interventions (Iwata, Wacker) but in a less controlled non-clinical setting such as a licensed day program or residential center

Request Information- Reason for Exposure Assessment

- Target behaviors are of significant complexity and intensity such that Descriptive Assessment , hypothesis of function and intervention plan addressing the identified problem variables is unlikely to be sufficient
- Descriptive Assessment is unlikely to provide sufficient indicators of possible functions of behavior as behavior is described to be highly likely in all situations, environments and with all individuals who are involved in caring for the child
- Descriptive Assessment has indicated inconclusive indicators of possible functions of behavior

Target Behaviors Identified for Exposure Assessment

- Target behaviors operationally defined and are able to be measured as discrete responses
- Target behaviors are of moderate to severe intensity
- Target behaviors do not present concerns for safety of individual or others if exposure assessment exacerbates them

Safety Precautions- Medical

- Medical review by medical professional who has indicated to what extent behaviors can be evoked and observed without intervention
- Medical review provides guidelines for when behaviors would require intervention to prevent harm
- Medical oversight at the time of the exposure assessment sessions has been determined unnecessary by medical professional
- Medical treatment services are secured and able to be provided in timely manner if interventions likely to cause injury

Safety Precautions- Environmental

- Property damage including broken glass or objects which could be thrown or used for weapons , is unlikely, or precautions including removing objects, barricading windows or unbreakable glass has been completed
- Sufficient assistance to evaluator is on hand to intervene if more than one person is required to safely intervene
- All persons who may be needed to intervene, including evaluator, are trained in safe physical management procedures

Evaluator Preparation for Exposure Assessment

- Formal training in exposure assessment methodology and data analysis has been completed
- Plan for exposure assessment conditions developed, environmental variables from descriptive assessment (possible antecedents and consequences) identified and included in conditions to individualize assessment to maximize results
- Data collection to be achieved through trained observer or evaluator has determined that data can be adequately collected by other means

Parent/Guardian Informed Consent- signed and dated consent obtained which specifies the possible dangers of the exposure assessment process

Discussion points .....

- What are some other activities that you might consider part of a FBA?
- What assessment service code do these activities fit under?
- What about re-assessment of skills/progress is this part of an FBA or protocol modification?

ABA INTERVENTION SERVICES

Adaptive Behavior Treatment with Protocol Modification

(0368 & 0369T)

- Done by QHCP or LaBA with direct oversight
- This is the bulk of behavioral services when no RBT is involved
- Ensure implementation train & modeling with individual for significant persons, monitor implementation and interpret data, modify strategies, write progress reports and plan updates
- Implement 1:1 skill training and reactive strategies with consultation for significant persons
- Provide supervision for LaBA or RBT
- 30 minute unit

Adaptive Behavior Treatment by Protocol by Technician

(0364 & 0365T)

- Done by RBT or LaBA with 10% of hours including on site supervision by LBA (0368/69T)
- Implement intervention strategies and collect data
- Model for significantly challenging situations/behaviors
- Document service data for dates provided
- 30 minute unit

Family Behavior Treatment Guidance

(0370T)

- Done by QHCP or LaBA
- Review and interpret assessment findings and intervention data
- Review forms and intervention plan strategies
- Model and practice intervention strategy implementation by significant persons
- Targeted individual not present due to disruption, discussion troubling to person or other clinically relevant reason
- Not all training or meetings will be this service, much of the time these will be done as protocol modification
- 60 minute unit

Behavior Treatment Social Skills Group (0370T)

- QHCP or LaBA works with group of individuals (up to 9)
- All with social skills/communication needs
- Can utilize curriculum/model and/or be activity based
- 90 minute unit

Exposure Adaptive Behavior Treatment with Protocol Modification (0373 & 0374T)

- LBA implements or directs RBT/LaBA to implement and reviews and analyzes data after each session (LBA present on site)
- Supervised by physician/QHCP with two or more technicians with individual for safe treatment
- Exposure of individual to specific environmental conditions and treatments that are likely to exacerbate the behaviors /likelihood of harm (eg. aversive stimuli, inappropriate sexual reaction, etc.)
- Data collection by technicians
- Refines therapy using single-case designs
- Modifies and/or replaces treatment regimen to meet indivdiual's needs in reaching treatment goals and generalizing skills
- Service provided in structured, safe environment
- Precautions may include environmental modifications and/or protective equipment
- 1st of date is 60 unit, add'l units of date are 30 min

Exposure Adaptive Behavior Treatment With Protocol Modification (0373T/0374T)

- See requirements for exposure assessment request
- QHCP designs, and is onsite directing, monitoring or implementing the procedures specific to the function of the behavior identified in the assessment
- Alternative behaviors are identified and targeted for acquisition or acceleration
- Treatment environment is specialized with safety parameters are identified and paramount
- First unit is 60 minutes, subsequent 30 minutes
- Billing only QHCP time
- Request should describe environment, dangerousness of behaviors, alternative behaviors procedures to be used, generalization plan

Discussion Points….

- What other behavior analytic tasks or activities might be part of providing ABA services?
- What codes do these fit under?

How do you figure out how much of what to request?

- Services/interventions must be individualized
- Must not replace educational or vocational services
- Must fit into the person's and support teams schedule, culture
- Base amount on intensity of need (behavior's targeted for change, tolerance of person/supports, resource availability, likelihood that amount of services will effect outcome (scientifically supported?)

Severity of Behavior *Estimator*

Rating	Intensity- indicate most severe level
1	Mild, no physical damage (occurs in residence, no law enforcement, not in community)
2	Less than 10% of episodes cause some light physical effect, (e.g. redness, property damage less than $20, property value less than $20, etc.)
3	More than 10% of episodes cause light physical effects, occurs in the neighborhood, no police involvement, redirects verbally)
4*	Between 10-45% cause some moderate physical effects (e.g. bruising, minor bleeding – first aide required, property damage under $100, at least1 had law enforcement involvement, no charges, required physical assistance, etc.)
5*	At least 50% cause some moderate physical effects, involvement of community members, police involvement, hospital//ER, multiple incidents requiring physical assistance)
6*	At least 10% cause some serious effects (e.g. Medical treatment required, property damage over $100, any law enforcement charges, psychiatric hospitalizations etc.)

Severity *estimator* continued

Rating	*Duration* of Episodes
1	Less than 2 minutes
2	Approximately 5-10 minutes
3	Approximately 15 -20 minutes
4	At least 30 - 45 minutes
5	More than 45 minutes
6	Can stop briefly, but restarts throughout the day

Severity Estimator continued

Rating	Frequency of each episodes
1	Less than monthly
2	Up to 2 times per month
3	Average of 4-6 times per month
4	Average of 2-3 times per week
5	About 1 -2 times per day
6	More than twice daily

- ADD Intensity + Duration + Frequency

Severity *Estimate*

Severity of Behavior Rating (can be moderated or exacerbated by family or care provider variables)

*Intensity with rating of 4-6 indicates severe intensity and highly likely to need for intensive behavioral services

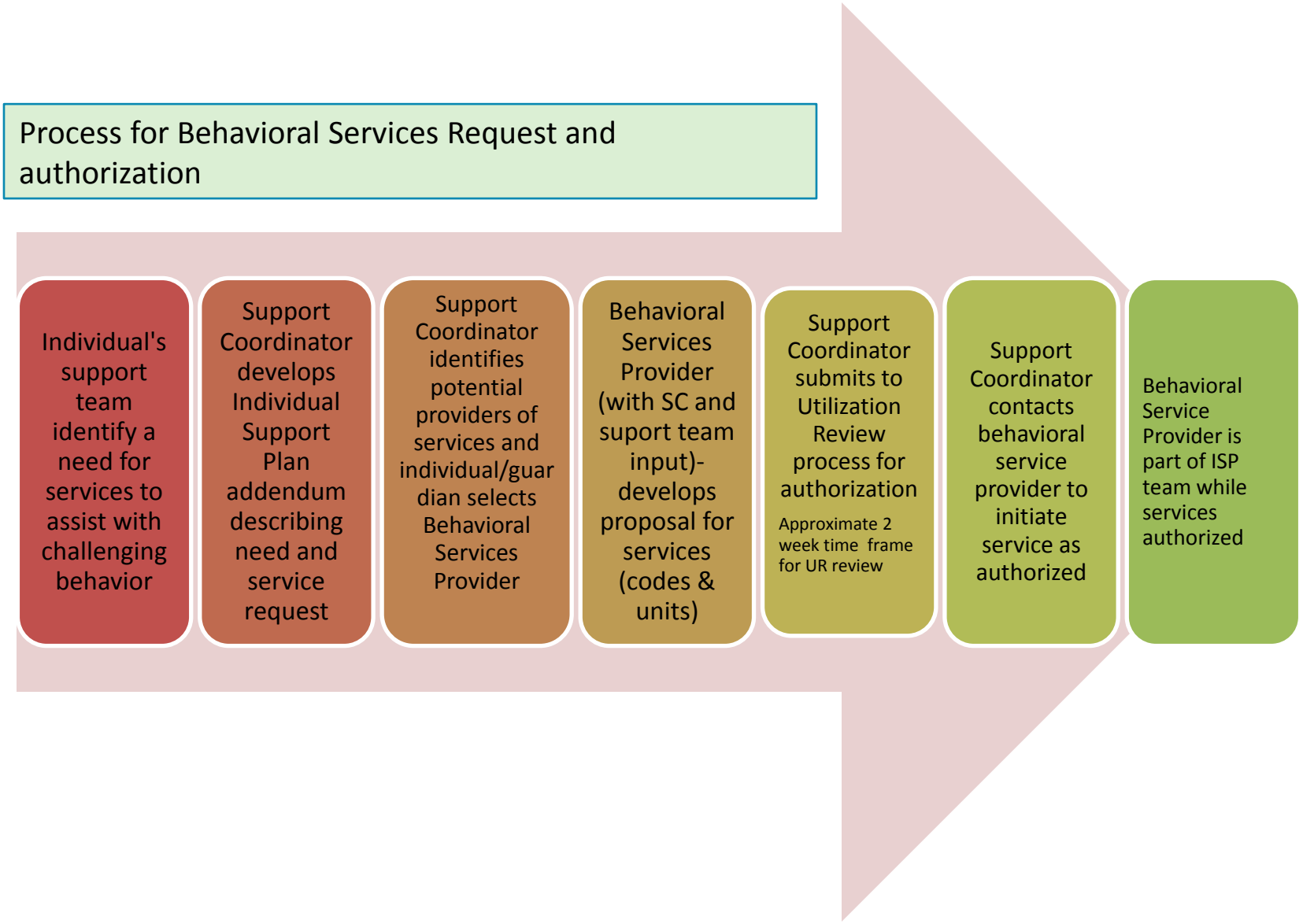
If Behavioral services necessary

3-6 Mild (Less involved, less intrusive, shorter term)
7-11 Moderate
12 - Severe (intensive, extensive, long term, LBA and additional implementers)

What *might* assessment and intervention requests look like for different intensity of behaviors?

Intensity of behavior	Assessment	Intervention
	This is not a model or recommendation for treatment, just an example of possible service units	
3-6 Mild	Behavior Identification 1-2 units Observation Assessment- 3 dates, 6-8 hours	Adaptive Behavior protocol modification- 2 hours per week X 46 -50 weeks Family treatment guidance- 6 - 8 hours
7-11 Moderate	Behavior Identification 2 units Observation Assessment- 3-5 dates,8-10 hours	Adaptive Behavior protocol modification- 2-3 hours per week X 46 -50 weeks Family treatment guidance- 6 - 8 hours
12 + Severe	Behavior Identification 2 units Observation Assessment- 3-5 dates,8-10 hours, Exposure Assessment- 8-10 sessions, 2 hours each	Above and Addition of Adaptive Behavior Treatment by Technician 3-5 hours, 5 days per week for 50 weeks Social Skills group 12 sessions

Process for Behavioral Services Request and authorization



MEDICAL NECESSITY- as defined by Mo HealthNet for Medicaid services

- Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury;
- to achieve age appropriate growth and development;
- to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered;
- and service(s) could *not* have been omitted without adversely affecting the participant's condition or the quality of medical care rendered;
- and service(s) is(are) furnished in the most appropriate setting.
- Services *must* be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity, and aren't mainly for the convenience of you or your doctor.

For preauthorization review

- You must have all required documentation and information
- It is helpful to have a brief explanation especially for atypical situations such as when you are asking for additional services for an already authorized service period (more assessment hours, adding services or hours)
- It is helpful to provide the anticipated schedule to verify the requested total for example – 15 hours per week with RBT – 3 hours per week day – instead of just total for 0364/65 -390 hours or 780 units

For preauthorization review

- Check to be sure you the request is within authorization limits
- Total the units/hours requests and check your math- discrepancies cause delays
- Faxed or scanned documents have to be legible
- It is helpful if these are sent in the correct order
- Duplicate documents in a request packet slow down the review process
- Color coded graphs are not interpretable, use different symbols for graphs instead
- Documentation is your evidence of medical necessity, no progress with no change in intervention strategy does not support medical necessity

General Medicaid Waiver Documentation Requirements

- Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized support living and at least quarterly for individuals who live in their natural home.
- As per 13 CSR 70 – 3.030, the provider is required to document the provision of Division of DD Waiver services by maintaining:
- First name, and last name, and either middle initial or date of birth of the service recipient.
- An accurate, complete, and legible description of each service(s) provided. This information may be included in daily activity records that describe various covered activities (services) in which the person participated.
- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. This may be included in attendance or census records documenting days of service, signed by the provider or designated staff; records indicating which staff provided each unit of service; and documentation of qualifications of staff to provide the service.
- Identify referring entity, when applicable.
- The date of service (month/day/year). This can be included in attendance or census records.
- Amount of time in hours and minutes spent completing the service. Prior to 6/1/07, for those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) the actual begin and end time taken to deliver the service (e.g., 4:00 – 4:30 p.m.) must be documented.
- This excludes services such as residential, home modification, equipment and supplies, transportation, etc. Effective 6/1/07. The begin and end time spent in delivering a service is no longer required.
- The setting in which service was rendered.
- Service plan, evaluation(s), test(s), findings, results, and prescription(s) as necessary.
- Service delivery as identified in the individual's service plan.

Questions?